No. 86-1419

Supreme Court, U.S.
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In the Supreme Court of the United States

OCTOBER TERM, 1986

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD,

Petitioners,

v.

COOS BAY CARE CENTER, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF FOR PETITIONERS

DAVE FROHNMAYER
Attorney General of Oregon
WILLIAM F. GARY
Deputy Attorney General
JAMES E. MOUNTAIN, JR.
Special Assistant to the Attorney General
***VIRGINIA L. LINDER**
Solicitor General
PHILIP SCHRADLE
Assistant Attorney General
400 Justice Building
Salem, Oregon 97310
Phone: (503) 378-4402
Counsel for Petitioners

*Counsel of Record

QUESTION PRESENTED

Do the rate reimbursement provisions established by the states in their Medicaid plans give rise to federal rights enforceable in federal court under 42 U.S.C. § 1983, when the pertinent parts of the federal Medicaid Act and its implementing regulations provide that reimbursement standards and administrative review procedures shall be established by the states?

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BRIEF FOR PETITIONERS

OPINIONS BELOW

The opinion of the Ninth Circuit Court of Appeals is reported as *Coos Bay Care Center v. State of Oregon, Department of Human Resources*, 803 F.2d 1060 (9th Cir. 1986). (Pet. App. A). The order and judgment of the district court is unreported. (Pet. App. B). The magistrate's Findings and Recommendations also are unreported. (Pet. App. C). The magistrate relied substantially upon the earlier decision of the District Court of Oregon in *Beecroft v. Atiyeh*, Civil No. 78-1027-BU (1982) which also is unreported. (Pet. App. D).

JURISDICTION

The opinion of the Ninth Circuit Court of Appeals was dated and filed on November 3, 1986. Judgment was entered on the same date. This Court has jurisdiction to review the judgment in this civil case by writ of certiorari pursuant to 28 U.S.C. § 1254(1) (1982). By order dated January 20, 1987, the Court extended the time for filing a petition for writ of certiorari to March 3, 1987. The petition was filed within the time allowed and was granted by this Court on May 4, 1987.

STATUTES AND REGULATIONS INVOLVED

1. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* (1982),[1] provides, in pertinent part:

> § 1396. For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services,

[1] 42 U.S.C. §§ 1396 *et seq.* have been amended since the date plaintiffs filed their complaint. However, the amendments do not have any substantial effect upon this case.

and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, ~~there is~~ hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, . . . State plans for medical assistance.

§ 1396a(a) A State plan for medical assistance must—

. . . .

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

. . . .

(13) provide—

(A) for payment . . . of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; . . . .

. . . .

(37) provide for claims payment procedures which . . . (B) provide for procedures of prepayment and postpayment claims ~~review~~, including review of appropriate data with respect to the recipient and provider

of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

. . . .

2. 42 U.S.C. § 1983 (1982) provides in pertinent part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. . . .

3. 42 C.F.R. § 431.220(a) (1984) provides in pertinent part:

> (a) The agency must grant an opportunity for a hearing to:
>
> (1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness; and
>
> (2) Any recipient who requests it because he believes the agency has taken an action erroneously.

4. 42 C.F.R. § 431.241 (1984) provides:

> The hearing must cover—
>
> (a) Agency action or failure to act with reasonable promptness on a claim for services, including both initial and subsequent decisions regarding eligibility; and
>
> (b) Agency decisions regarding changes in the type or amount of services.

5. 42 C.F.R. § 431.246 (1984) provides:

> The agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, if—
>
> (a) The hearing decision is favorable to the applicant or recipient; or

(b) The agency decides in the applicant's or recipient's favor before the hearing.

6. 42 C.F.R. § 447.253(c) (1984) provides:

(c) *Provider appeals.* The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

STATEMENT OF THE CASE

Plaintiff Coos Bay Care Center ("CBCC") is an intermediate care facility that provides long-term health care services for the developmentally disabled and the aged. (Findings and Recommendation, Pet. App. C at App-10). CBCC participates as a health care provider in Oregon's Medicaid program. (*Ibid.*). The individual plaintiffs are resident patients at CBCC. (J.A. at 3). Defendant Oregon Department of Human Resources ("DHR") is the Oregon agency responsible for administering the state's Medicaid program. (Findings and Recomendation, Pet. App. C at App-10). Defendant Richard C. Ladd is Administrator of the DHR division which directly administers Oregon's Medicaid program. (*Ibid.*).

Plaintiffs sued under 42 U.S.C. § 1983 (1982) on their own behalf and on the behalf of others similarly situated. They sought damages, injunctive and declaratory relief and certification as a class action. Plaintiffs alleged that defendants erroneously failed to classify certain patients (including the individual plaintiffs) as "heavy cost" care patients and, accordingly, failed to reimburse plaintiff CBCC at the special rate applicable under Oregon's Heavy Cost Program for care of those patients. (J.A. at 5).

Oregon's Heavy Cost Program is defined narrowly by state administrative rules. To be eligible, patients must be functional quadriplegics "ready for discharge from an acute care hospital or whose care could be provided in a nursing facility

in lieu of placement in an acute care hospital." Or. Admin. R. 411-70-030(1)(b). The heavy cost reimbursement rate is expressly identified as an "add-on to the facility's established rate for the clients' level of care." Or. Admin. R. 411-70-030(7)(b).[2]

A facility's basic reimbursement rate for care provided to all patients under Oregon's Medicaid program is determined under the provisions of a separate administrative rule that defines an all-inclusive rate for "all services, supplies and facility equipment required for care." Or. Admin. R. 411-70-085(1).[3] Oregon's Medicaid plan establishes the 75th percentile as the rate that reasonably will reimburse an efficiently and economically operated facility. Or. Admin. R. 411-70-440(2).[4] Under Oregon's plan, if a facility's claimed costs for providing services included in the all-inclusive or established rate fall within the lower 75 percent of costs incurred by all eligible facilities, Oregon reimburses the facility for all of its claimed costs. If its claimed costs are greater than the costs incurred by those within the lower 75th percentile, Oregon reimburses the facility only at the 75th percentile rate.

The "established rate" in Oregon's Medicaid plan thus is the reimbursement rate that the state has found will adequately reimburse efficiently operating facilities for services provided to Medicaid patients. The special add-on "heavy cost" reimbursement rate provides complete reimbursement

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[2] Or. Admin. R. 411-70-030(1) and (7) are set out in full in Pet. App. F at App-39.

[3] Or. Admin. R. 411-70-085(1) and (2) are set out in full in Pet. App. G at App-41.

[4] Or. Admin. R. 411-70-440 is set out in full in Pet. App. H at App-43.

through a special daily rate for services provided to patients who meet the requirements of the Heavy Cost Program.

Plaintiffs' complaint alleged that certain patients who qualify under the state's Heavy Cost Program have been denied eligibility for that program. (J.A. at 5-6). Plaintiffs alleged that defendants' failure to treat certain patients as "heavy cost" patients breached the provider contract, violated state law, and violated the provider's and patients' rights under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* (1982).

The case was assigned to a United States Magistrate for findings and recommendations. The magistrate determined that 42 U.S.C. §§ 1396 *et seq.* did not create enforceable rights or a private right of action and that plaintiffs, therefore, could not sue under 42 U.S.C. § 1983. The District Court of Oregon adopted the magistrate's findings and recommendation and dismissed plaintiffs' complaint with prejudice and without leave to amend. The court entered judgment for defendants.

Plaintiffs appealed to the Ninth Circuit Court of Appeals. The Ninth Circuit held that plaintiffs' complaint alleged a violation of federal statutory rights cognizable under 42 U.S.C. § 1983. The court, therefore, reversed and remanded for further proceedings. On certiorari review by this Court, petitioners seek reversal of the Ninth Circuit's decision.

SUMMARY OF ARGUMENT

The Ninth Circuit has held that 42 U.S.C.§ 1983 provides a vehicle for federal judicial oversight of every aspect of a state's administration of its Medicaid program. This conclusion would expand dramatically federal court jurisdiction to review state legislative and executive conduct in connection with cooperative state-federal funding programs. Yet the appeals court reached this result without any discussion of the nature of the federal legislation involved, the limits on federal

court jurisdiction, or the vital importance of state sovereign immunity in our federal system. These considerations should have been the starting point in the analysis.

"Cooperative federalism" programs such as Medicaid are essentially contracts wherein two sovereigns agree to a division of governmental power and responsibility with respect to an area of mutual concern. Congress proposes the terms of the contract in the act creating the program. States accept those terms by electing to participate. The extent of federal judicial supervision of state functions in cooperative programs is a critical term of the agreement because it defines federal jurisdiction and correspondingly reduces the Eleventh Amendment immunity of participating states. Congress, therefore, should indicate its intention to provide for federal court enforcement of such an act in unmistakable terms in the act itself.

The appeals court ignored these basic federalism issues because it construed this Court's decision in *Maine v. Thiboutot* to hold that 42 U.S.C. § 1983 provides a remedy for any violation of federal law by state officials. However, this Court has always recognized that the threshold inquiry in any suit to enforce an act of Congress is whether the federal law creates the enforceable statutory rights asserted by the plaintiffs. Because the effect of recognizing federal statutory rights in the context of "cooperative federalism" programs is to define the scope of federal judicial oversight, the federal rights analysis should be guided by principles of federalism.

Plaintiffs contend that the Medicaid Act creates a federal statutory right to have individual provider reimbursement decisions measured against a federal standard. Nothing in the Medicaid Act remotely says this. Furthermore, recognition of a federal right to a specific level of provider reimbursement would be inconsistent with the history, purpose, and structure of the Medicaid Act.

The Medicaid Act specifies that provider reimbursement is to be made according to payment rates set by the states. These rates are to be "determined in accordance with methods and standards developed by the states." 42 U.S.C. § 1396a(a)(13)(A). The Act sets forth objectives that states are to consider in fixing rates; it does not provide a standard for evaluating individual reimbursement decisions.

The current state-controlled reimbursement scheme is the product of years of congressional and administrative trial and error. As originally enacted, the provisions of the Medicaid Act and its implementing regulations encouraged states to reimburse providers according to national Medicare rates. The use of a national standard proved inflationary and inefficient. Therefore, in 1980 Congress deliberately chose to make reimbursement standards a matter of state law.

The entire thrust of the Medicaid scheme is to leave the development of provider reimbursement rates, the administration of reimbursement programs and the review of individual reimbursement decisions to the states. The guiding principle is that medical costs can be managed more effectively through decentralized state control. The Act is designed to facilitate diversity in reimbursement levels from state to state. This overall purpose would be frustrated by recognition of a judicially enforceable national reimbursement standard.

The availability of federal judicial review for each state's provider reimbursement decisions would encourage forum shopping, duplicative actions and inconsistent adjudications. Such review would run counter to the basic structure of the Act. Federal law provides for *state* administrative appeals of reimbursement decisions precisely because those decisions are governed by state law. It makes no sense to recognize an alternative federal forum for such appeals because Congress

has provided no meaningful standard of review for federal courts to apply.

The Ninth Circuit's decision is wrong because Congress did not express or even hint at an intention to create federal provider reimbursement rights. The effect of the court's decision is to undermine substantially the basic principles of federalism and state sovereign immunity embodied in the Eleventh Amendment. Those principles should have constrained the Ninth Circuit's construction of the Medicaid Act. Notwithstanding this Court's Eleventh Amendment jurisprudence, the appeals court directed the trial court to entertain an action for retroactive and prospective relief against a state.

This Court has never permitted Congress to erode state immunity by innuendo. Clearly it should not countenance such erosion when the entire statutory scheme demonstrates a contrary intention.

ARGUMENT

I. Introduction.

At its core, this case graphically illustrates principles that are basic to state-federal relations and to the jurisdiction of the federal courts. However, the well-settled rules that control this case have been obscured by the dizzying amalgam of state and federal statutes under which it arises. The complex provisions of the Medicaid program, 42 U.S.C. §§ 1396 *et seq.*, may readily explain the analytic disorientation that characterizes the opinion of the Ninth Circuit. But the result reached by the appeals court is so at odds with precedent and common sense that it should have signaled the court to retrace its steps to find where it made a wrong turn.

Plaintiffs sued the State of Oregon, one of its agencies and one of its officials in federal court, in connection with the administration of the state's Medicaid plan. They sought to

recover money damages as well as declaratory and injunctive relief. Their claim relates to the state's alleged failure to make "specific and complete reimbursement" to CBCC for its provision of "heavy cost care." Both the concept of "heavy cost care" and the formula according to which such care is to be reimbursed are creatures of state law. State administrative rules define "heavy cost" reimbursement as an "add-on" to the state's established Medicaid rate. No federal statute or regulation even mentions the program or the concept of "heavy cost care."

The Ninth Circuit held that the plaintiffs' complaint stated a claim under 42 U.S.C. § 1983. (Pet. App. A at App-5). In an astonishing vault of logic, the court reached this result without any mention of its plain inconsistency with innumerable prior decisions of this Court. The appeals court thus recognized a § 1983 action commenced directly against a state in federal court, although this Court has held that the Eleventh Amendment bars federal courts from entertaining suits for retrospective and prospective relief against a state. *Edelman v. Jordan*, 415 U.S. 651 (1974). The lower court permitted Oregon's participation in the Medicaid program to subject the state to federal court jurisdiction without a state waiver or congressional abrogation of Eleventh Amendment immunity, despite this Court's repeated holding that such waiver or abrogation must be clearly expressed. *Welch v. Texas Dept. of Highways and Public Transportation*, ___ U.S. ___, 107 S.Ct. ___, 55 U.S.L.W. 5046, 5047 (June 25, 1987); *Atascadero State Hospital v. Scanlon*, 473 U.S. 234, 242 (1985). And the appeals court found that federal jurisdiction exists in this case, although plaintiffs' claim is that the state has failed to make "heavy cost" reimbursement as provided by *state* law. It is axiomatic, however, that state-law-based claims do not provide a basis for federal jurisdiction. *See Gully v. First National Bank in Meridian*, 299 U.S. 109 (1936);

See also Pennhurst State School and Hospital v. Halderman, 465 U.S. 89, 120 (1984) (*Pennhurst II*) (Eleventh Amendment bars federal court adjudication of pendent state law claims against state officials).

The Ninth Circuit's decision completely ignored the building blocks of federalism that this Court has so carefully quarried. Relying exclusively upon *Maine v. Thiboutot*, 448 U.S. 1 (1980) (*Thiboutot*), the appeals court summarily concluded that 42 U.S.C. § 1983 is available "to compel participating states to comply with the provisions of the Social Security Act." (Pet. App. A at App-2). For the Ninth Circuit, plaintiffs' claims are invested with an overarching "federalness" merely because they arise in the Medicaid context. The appeals court held that this fact simultaneously confers federal jurisdiction, creates federal rights, and abrogates Eleventh Amendment immunity.

The result in this case stands cooperative federalism on its head and turns all cooperative funding programs into coercive vehicles of federal dominance. *Thiboutot*, read in context with other decisions of this Court, should not be interpreted to require this result. Last term, in *Welch v. Texas Dept. of Highways and Public Transportation*, *supra*, the Court reiterated the importance of federalism principles in determining whether a claim against a state is properly before it:

> We have been unwilling to infer that Congress intended to negate the state's immunity from suit in federal court, given the vital role of the doctrine of sovereign immunity in our federal system. . . . Moreover, the courts properly are reluctant to infer that Congress has expanded our jurisdiction.

55 U.S.L.W. at 5048. Cases decided subsequent to *Thiboutot* demonstrate that these same considerations should guide the determination whether the provisions of a state-federal cooperative funding statute, such as Medicaid, are enforceable against the states in federal court under 42 U.S.C. § 1983. *See*

Pennhurst State School and Hospital v. Halderman, 451 U.S. 1 (1981) (*Pennhurst I*); *Middlesex County Sewerage Authority v. National Sea Clammers Association*, 453 U.S. 1 (1981) (*Sea Clammers*).

Cooperative funding programs essentially are contracts between states and the federal government. Through these programs, two sovereigns agree jointly to fund and administer programs for the public welfare. If every aspect of these programs automatically is enforceable in federal court, then states are required to subject themselves and their programs to federal judicial supervision as the price of admission to the cooperative funding program. If Congress intends to extract such a price, it should say so plainly. When it has not clearly expressed such an intention, courts should not infer it.

The Ninth Circuit concluded that *Pennhurst I*, *supra*, and *Sea Clammers*, *supra*, merely narrowed *Thiboutot* "as applied to some federal statutes. . . ." (Pet. App. A at App-2). In doing so, the appeals court ignored the guidance that those cases provide as to the meaning and application of *Thiboutot*. The appeals court's approach to this case is thereby seriously flawed.

42 U.S.C. § 1983 does not create a cause of action for *every* violation of *every* federal statute. *Pennhurst I*, *supra*. It confers a remedy for deprivations (made under color of state law) of "*rights, privileges, or immunities* secured by the Constitution and laws" of the United States. Therefore, the relevant inquiry is not whether the plaintiffs' claim involves federal law, but whether the federal law involved creates rights, privileges or immunities.

In effect, the court of appeals has held that Title XIX of the Social Security Act confers upon Medicaid providers and patients alike a generalized right to Medicaid funding and reimbursement. This right embraces every detail of every federal statute and administrative regulation pertaining to the

Medicaid program, no matter how it is phrased, to whom it is directed or what it concerns. Apparently, the right also embraces every state regulation adopted in connection with the cooperative program. In the context of state-federal cooperative funding programs, the result of this holding is to take away through 42 U.S.C. § 1983 all of the protection against federal judicial intervention that principles of federalism provide.

This case turns on whether Congress intended the Medicaid Act to convert state plan provisions, adopted consistent with the general objectives of the Act, into federal statutory rights, enforceable against the states. In a federal system in which the composition and structure of Congress is itself relied upon "to insulate the interests of the states," *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528, 551 (1985) (*Garcia*),[5] the Court should not infer such an intent from congressional silence. As with abrogation of Eleventh Amendment immunity, the Court should require that congressional intent to create enforceable statutory rights in cooperative funding acts be expressed in "unmistakable language in the statute itself." *Atascadero State Hospital v. Scanlon*, 473 U.S. at 243.

The Medicaid Act cannot be construed to create provider reimbursement rights enforceable against the states in federal

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[5] In *Garcia*, the Court placed special reliance on Congress' concern and deference for state sovereignty. Justice Blackmun, writing for the Court, observed:

> Apart from the limitation on federal authority inherent in the delegated nature of Congress' Article I powers, the principal means chosen by the Framers to ensure the role of the States in the Federal system lies in the structure of the Federal Government itself. It is no novelty to observe that the composition of the Federal Government was designed in large part to protect the States from overreaching by Congress. . . .

469 U.S. at 550.

court. Nothing in the Medicaid Act remotely suggests congressional intent to create such rights. To infer their existence would contradict the language, history, purpose and structure of the Act. Moreover, such a construction of the Medicaid Act would directly conflict with the Eleventh Amendment, which stands as a bar to federal judicial review of the claims asserted.

II. Title XIX of the Social Security Act Does Not Create Any Federal Rights That Are Implicated in This Case.

A. *Maine v. Thiboutot* and the Federal Rights Analysis.

The Ninth Circuit's decision badly mangles basic federalism principles because it reads more into *Maine v. Thiboutot* than is there. This Court has always held that federal statutes are enforceable through private actions *only* to the extent that they create rights personal to the plaintiff. *Thiboutot* does not alter that rule. *Thiboutot* holds that 42 U.S.C. § 1983 creates a cause of action for deprivation (under color of state law) of any federal statutory *right*. The Court rejected arguments by the State of Maine and various amici that § 1983 was intended to provide a remedy only for violation of constitutional rights and of laws enacted pursuant to section 5 of the Fourteenth Amendment to protect those rights.[6]

Prior to *Thiboutot*, both this Court and lower courts sometimes assumed that § 1983 was available to remedy violations of rights created in non-civil rights stat-

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[6] 448 U.S. at 6-7. *See* Brief for Petitioners, 10-18; Brief Amici Curiae for the Commonwealth of Pennsylvania and the States of New Hampshire, New Jersey, Rhode Island, Vermont and Delaware, 4-9. *See also Chapman v. Houston Welfare Rights Organization*, 441 U.S. 600, 623 (1979) (Powell, J., concurring).

utes.[7] However, the principal inquiry in suits to enforce acts of Congress was whether the act included either express or implied authorization for private enforcement. It mattered little that a federal statute created *substantive* rights, if Congress had not authorized a *procedure* to vindicate those rights. Thus, in *Cort v. Ash*, 422 U.S. 66 (1975) and its progeny, the Court employed a four-factor analysis to determine whether Congress intended to create an implied private right of action to enforce a federal statute.[8] Through this

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[7] *See, e.g., Miller v. Youakim*, 440 U.S. 125 (1979) (Aid to Families with Dependent Children Foster Care Program); *Edelman v. Jordan*, 415 U.S. 651 (1974) (Aid to Aged, Blind and Disabled); *Hagans v. Lavine*, 415 U.S. 528 (1974) (Aid to Families with Dependent Children); *Louise B. v. Colautti*, 606 F.2d 392 (3d Cir. 1979) (Aid to Families with Dependent Children); *Tongal v. Usery*, 601 F.2d 1091 (9th Cir. 1979) (Emergency Unemployment Compensation Act of 1974); *Blue v. Craig*, 505 F.2d 830 (4th Cir. 1974) (Medicaid); *Gomez v. Florida State Employment Service*, 417 F.2d 569 (5th Cir. 1969) (Wagner-Peyser Act of 1933).

No Supreme Court decision prior to *Thiboutot* held that § 1983 applied to non-civil rights statutes. The rule was assumed in the course of disposing of other questions. *Maine v. Thiboutot*, 448 U.S. at 31 (Powell, J., dissenting). Some lower courts had refused to extend the reach of § 1983 beyond the protection of Fourteenth Amendment rights. *See, e.g., McCall v. Shapiro*, 416 F.2d 246, 249-50 (2nd Cir. 1969); *Wynn v. Indiana State Department of Public Welfare*, 316 F.Supp 324, 330-33 (N.D. Ind. 1970).

[8] The Court explained:

> In determining whether a private remedy is implicit in a statute not expressly providing one, several factors are relevant. First, is the plaintiff "one of the class for whose *especial* benefit the statute was enacted," . . . that is, does the statute create a federal right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? . . . Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff? . . . And finally, is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law?

Cort v. Ash, 422 U.S. 66, 78 (1975) (citations omitted, emphasis in original). *See also Touche Ross and Co. v. Redington*, 442 U.S. 560 (1979); *Davis v. Passman*, 442 U.S. 228 (1979); *Cannon v. University of Chicago*, 441 U.S. 677 (1979); *Chrysler Corporation v. Harold Brown*, 441 U.S. 281 (1979).

implied right of action analysis, consideration of the nature of substantive federal rights was subsumed in the search for an enforcement vehicle.

Under *Cort v. Ash*, whether the inquiry was made in the context of suits between private parties,[9] against federal officials,[10] or against persons acting under color of state law,[11] the decision to imply a private right of action largely was based on whether Congress intended to create rights personal to the plaintiff. As the Court noted in *Cannon v. University of Chicago*, 441 U.S. 677 (1979), with only one exception,

> this Court has never refused to imply a cause of action where the language of the statute explicitly conferred a right directly on a class of persons that included the plaintiff in the case. . . . [c]onversely, the Court has been especially reluctant to imply causes of action under statutes that create duties on the part of persons for the benefit of the public at large.

441 U.S. at 690 n. 13.

After *Maine v. Thiboutot*, 42 U.S.C. § 1983 provides a prefabricated enforcement vehicle for violation of federal statutory rights under color of state law. Therefore, when § 1983 is available, it is unnecessary to determine whether there is an implied right of action in a substantive act of Congress.[12] Nevertheless, both before *Thiboutot*, (*see, e.g., Cannon v. University of Chicago, supra,*) and after (*see, e.g.,*

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[9] *See, e.g., Santa Fe Industries, Inc. v. Green*, 430 U.S. 462 (1977).

[10] *See, e.g., Chrysler Corporation v. Harold Brown*, 441 U.S. 281 (1979).

[11] *See, e.g., Middlesex County Sewerage Authority v. National Sea Clammers*, 453 U.S. 1 (1981).

[12] The complaint in this case alleges the existence of a cause of action directly under 42 U.S.C. § 1396a as well as under 42 U.S.C. § 1983. (J.A. at 8). The assertion of an implied private right of action under the Medicaid Act is superfluous. Plaintiffs have no implied right of action under the Medicaid Act unless the Act confers federal rights on them, *Cort v. Ash, supra.* If the Act in fact confers those rights, 42 U.S.C. § 1983 provides a remedy unless the *express* remedial scheme in the statute is exclusive. *See Sea Clammers*, 453 U.S. at 20-21 (1981).

Pennhurst I, supra,) a federal statute will support a claim for relief *only* if Congress intended for the statute to confer the personal rights asserted in the claim.

Thus, to determine whether plaintiffs have alleged an enforceable claim, the Court first must identify the specific federal rights that plaintiffs contend defendants have violated (II, B). The Court must then examine the Medicaid Act itself, to determine whether it confers those rights. The language of the Medicaid Act (II, C) does not remotely suggest the creation of the rights plaintiff's assert. Moreover, the Act's history (II, D), purpose (II, E), and structure (II, F) would be undermined by recognition of those rights. More fundamentally, the Ninth Circuit's misapplication of the federal rights analysis led it directly to controvert the basic principles of federalism embodied in the Eleventh Amendment (III).

B. Alleged Federal Statutory Rights.

The Ninth Circuit did not identify the federal statutory rights asserted by the plaintiffs or explain how those rights allegedly were violated. The task is difficult because the complaint has a chameleon-like quality. The scant factual allegations take on an appearance of federal significance only because they are cast against the background of a state-federal program. Yet, upon close examination, there is little in the complaint to indicate what action by defendants violated what alleged federal rights.

The most common sense reading of the complaint suggests that defendants have refused to provide the special add-on heavy cost reimbursement to Coos Bay Care Center for patients who purportedly qualify for it under *state* law and under the state's Medicaid plan.[13] The complaint appears to

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[13] Plaintiffs' complaint alleges:

> In spite of the qualification of the patients, the State of Oregon and Defendant Richard C. Ladd, acting under color of state law,

(Footnote continued on next page)

allege a claim arising under state law and under the provider contract between CBCC and the State of Oregon. Plaintiffs allege, however, that the conduct "violates 42 U.S.C. § 1396a *et seq.* and 42 C.F.R. § 447.252." (J.A. at 8). Thus, plaintiffs appear to contend that there is a federal statutory right to absolute compliance with every provision of state law relating to the state's participation in the Medicaid program.[14] Cast in its starkest terms, this assertion means that every administrative error by state officials in connection with their administration of the state Medicaid plan would implicate federal rights and would give rise to a federal cause of action under 42 U.S.C. § 1983. However, *sub silentio* conversion of every provision of state law into a federal right would be a dramatic step for Congress to take. Given the traumatic effect on state-federal relations that such a requirement would cause, the intent to "federalize" state law should be expressed plainly.

In their Brief in Opposition to Certiorari, plaintiffs appear to suggest that a more modest claim is intended. They now read their complaint to allege that the state's administration

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> have developed an unconstitutional de facto policy procedure, custom and usage of consistently and repeatedly refusing to pay the cost of the heavy care patients to and on behalf of the Plaintiffs. . . .

(J.A. [illegible] 6).

[14] Plaintiffs also claimed that the denial of heavy cost reimbursement constituted a taking of property without due process or just compensation. *See* J.A. at 6. Apart from whatever entitlements are conferred under the terms of the Medicaid Act itself, plaintiffs have no protected interest in a particular level of provider reimbursement entitling them to process or compensation before the government can reduce their reimbursement. *Cf. Bowen v. Gilliard*, ___ U.S. ___, 107 S.Ct. ___, 55 U.S.L.W. 5079 (June 25, 1987) (welfare benefit recipients do not have a property interest in a particular level of benefits; statutory changes in their entitlements therefore do not result in a taking). Those allegations accordingly did not provide an independent basis for relief. This undoubtedly explains why neither the district court nor the Ninth Circuit addressed these claims.

of its Medicaid plan does not "comply with *federal* law." (Br. in Opposition to Cert. at 4) (emphasis in original). By this, plaintiffs presumably mean that federal law creates a right to reimbursement according to a certain defined federal standard and that, in specific instances, Oregon's reimbursement practices fail to satisfy that standard.[15] This assertion also has broad ramifications. If there is a federal statutory right to have individual state provider reimbursements measured against a federal standard, then every provider payment, by every state participating in the Medicaid program, is a potential federal cause of action under 42 U.S.C. § 1983. This broad sweep of potential federal judicial supervision is so at odds with the states' traditional immunity from suit in federal court and would so greatly expand the scope of federal jurisdiction, that Congress should express the creation of such a federal right in "unmistakable language." *Atascadero State Hospital v. Scanlon*, 473 U.S. at 243.

Regardless how the complaint is read, it alleges broad new federal statutory rights that this Court never has recognized. Therefore, we must examine the Medicaid Act and its implementing regulations to identify the source of the rights asserted.

C. The Language of the Medicaid Act.

No terms in the Medicaid Act or its implementing regulations embody a provider right to reimbursement at a particular level. The Medicaid Act creates a cooperative state-federal

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[15] The Ninth Circuit appears to have assumed that this was plaintiff's claim. In the last paragraph of its opinion, the circuit court offered the following guidance to the district court and to the parties as to how plaintiffs' claim is to be evaluated:

> To prevail on the merits, plaintiffs must convince the trial court that the actions and non-action of the State of Oregon violate the standard set out in 42 U.S.C. § 1396a(a)(13)(A).

(Pet. App. A at App-5).

mechanism to provide medical assistance, rehabilitation and other services to eligible persons through a program administered by participating states. Exercising its spending power under article I, section 8, clause 1 of the United States Constitution,[16] Congress annually appropriates money for the matching fund program, pursuant to the authorization contained in 42 U.S.C. § 1396. Plaintiffs' complaint allegedly is based, in part, on § 1396, but that statute provides:

> For the purpose of enabling each State, *as far as practicable under the conditions in such State*, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. *The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, . . . State plans for medical assistance.*

(Emphasis added). Thus, states that opt for Medicaid participation must develop detailed plans for administration of the state medical assistance program. Those plans must be approved by the Secretary of Health and Human Services before federal funds are disbursed. 42 U.S.C. § 1396a(a) details what the state plan for medical assistance must include.

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[16] The Medicaid Act was first enacted in 1965 as Sec. 121 of Pub. L. 89-97. The Act added Title XIX to the Social Security Act (codified at 42 U.S.C. §§ 1396 *et seq.*). The Social Security Act is a valid exercise of Congress' power under article I, § 8 of the United States Constitution, to lay and collect taxes to provide for the general welfare. *See Helvering v. Davis*, 301 U.S. 619 (1937); *Steward Machine Co. v. Davis*, 301 U.S. 548 (1937); *Carmichael v. Southern Coal Co.*, 301 U.S. 495 (1937).

In their complaint, plaintiffs invoke subsection (13)(A) of 42 U.S.C. § 1396a(a). That subsection specifies that a state plan for medical assistance must provide:

> for payment . . . of the . . . intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the state . . .) . . . *which the state finds*, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards and to assure that individuals . . . have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality. . . .

42 U.S.C. § 1396a(a)(13)(A) (emphasis added).

Plaintiffs also rely upon regulations[17] adopted by the Health Care Financing Administration (HCFA) to implement 42 U.S.C. § 1396a(a). Like the statute, HCFA's implementing regulations merely identify general objectives that the state-developed provider reimbursement rates are to serve.[18] HCFA's regulations also require that participating

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[17] This Court has never considered whether administrative regulations alone can create rights enforceable under 42 U.S.C. § 1983. *See Wright v. City of Roanoke Redevelopment and Housing Authority*, ___U.S. ___, 107 S.Ct. 766, 778 (1987) (O'Connor, J., dissenting).

[18] 42 C.F.R. § 447.253 (1984) provides in pertinent part:

> (a) *State assurances.*. In order to receive HCFA approval of a significant State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (g) of this section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.
>
> (b) *Findings.* Whenever the Medicaid agency makes a significant change in its methods and standards, but not less often than annually, the agency must make the following findings:

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states provide an appeals procedure through which providers may obtain review of state-established reimbursement rates. 42 C.F.R. § 447.253(c) (1984).

In sum, 42 U.S.C. § 1396a and its implementing regulations merely require participating states to develop reimbursement rates, *according to state standards and methods*, that *"the state finds"* are reasonable and adequate to meet specified ratemaking criteria. Participating states also are required to provide for "prompt administrative review" of provider chal-

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(1) *Payment rates.* (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

. . . .

(2) *Upper limits.* The Medicaid agency's estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services or long-term care facility services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

(c) *Provider appeals.* The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

(d) *Uniform cost reporting.* The Medicaid agency must provide for the filing of uniform cost reports by each participating provider.

(e) *Audit requirements.* The Medicaid agency must provide for periodic audits of the financial and statistical records of participating providers.

(f) *Public notice.* The Medicaid agency must provide that it has complied with the public notice requirements in § 447.205 of this part when it is proposing significant changes to its methods or standards for setting payment rates for inpatient hospital or LTC facility services.

(g) *Rates paid.* The Medicaid agency must pay for inpatient hospital and long term care services using rates determined in accordance with methods and standards specified in an approved State plan.

lenges to the adequacy of those rates. Plaintiffs contend that these provisions of federal law entitle them to obtain federal judicial review of provider reimbursement decisions made at the state level. Plaintiffs are wrong. These provisions neither create nor signal personal rights to a particular level of reimbursement.

The words used in a statute are crucial in determining the statute's legal effect. When Congress intends to confer personal rights, it is capable of using words that clearly express its purpose and fully describe the entitlement created.[19] Moreover, the presence or absence of congressional intent to confer rights is irrelevant if Congress does not *promulgate* that intent through the words of a statute. *See* L. TRIBE, CONSTITUTIONAL CHOICES 30-31 (1985). Thus, an act that provides that "[a]ll persons shall be entitled to the full and equal enjoyment of the goods, services, facilities, privileges, advantages and accommodations of any place of public accommodation. . ." 42 U.S.C. § 2000(a) (1982), clearly embodies a declaration of personal rights. An act which provides that "[n]o person shall sell, or offer for sale colored oleomargarine . . . unless . . . it is clearly labeled as margarine," 21 U.S.C. § 347 (1982), may just as clearly benefit consumers, but the prohibitory language indicates Congress' intent to create a duty for the benefit of the public at large, rather than a desire to confer individual entitlements. *See Cannon v. University of Chicago*, 441 U.S. at 690 n. 13. The Medicaid Act provisions upon which plaintiffs rely fall into this second category.

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[19] *See Cannon v. University of Chicago*, 441 U.S. at 690 n. 13; *Schwegmann Brothers v. Calvert Distillers Corp.*, 341 U.S. 384, 395 (1951) (Jackson, J., concurring). As Justice Jackson later observed, statutory interpretation must proceed "by analysis of the statute instead of by psychoanalysis of Congress." *United States v. Public Utilities Commission*, 345 U.S. 295, 319 (1953) (Jackson, J., concurring). *See generally* L. TRIBE, CONSTITUTIONAL CHOICES 30-31 (1985); Frohnmayer, *Of Legislative Intent, The Perils of Legislative Abdication and the Growth of Administrative and Judicial Power*, 22 WILLAMETTE L. REV. 219 (1986).

Plaintiffs contend that 42 U.S.C. § 1396a(a)(13)(A) creates a right to provider reimbursement at a particular level,[20] as determined pursuant to a federal standard. Alternatively, they contend that Congress intended to make strict compliance with state Medicaid laws a matter of federal statutory right. It would require unbelievable distortion of the statutory language to convert that section from a requirement that the state pursue certain objectives in developing provider reimbursement rates, to a requirement that each reimbursement decision be measured against the broad goals of the statute. The statute provides no standards applicable to state reimbursement practices; it sets forth objectives which the

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[20] Plaintiffs in this case include persons acting as guardians ad litem on behalf of patients who are alleged to qualify as "heavy care" patients under the Oregon Heavy Cost Program. The complaint includes class action allegations whereby these plaintiff patients seek to represent all other "heavy care" patients. (J.A. at 6-7). The only operative facts alleged with respect to the patient claims in this case are:

> [T]he plaintiffs' wards . . . and the class they represent do not receive the quantity or quality of care guaranteed to them constitutionally and by state and federal laws, statutes, and regulations and as aforesaid, although Plaintiff Coos Bay Care Center does afford "heavy care" patients as much "heavy care" as possible.
>
> Throughout the State of Oregon there are other heavy care patients residing within long term health care facilities who similarly qualify for heavy care but who do not receive the full amount of appropriate care because of the refusal of the Defendants to appropriately reimburse health care providers for such care.

(J.A. at 6).

Thus, the plaintiff patients allege that private long-term health care facilities are failing to provide adequate care to patients because the state is violating the *provider's* right to adequate reimbursement. The plaintiff patients do not allege any other breach of rights by the state, they merely allege that they are being harmed by that breach. While their allegations of injury *may* give the patients standing to assert the provider's right to reimbursement, *see, e.g., Simpson v. Heckler*, 630 F. Supp. 736 (E.D. Pa. 1986); *Thomas v. Johnston*, 557 F.Supp. 879, 902-04 (W.D. Tex. 1983), they do not add anything to the substantive claims in this case. Whatever recourse the patients may have against health care facilities which fail to provide adequate care, their presence in this case does not create a federal right to a particular level of provider reimbursement, where none otherwise exists.

state is to consider in *fixing rates*. Reimbursements are governed by rate, not by the generalized goals of the statute. In fact, to the extent that the section contemplates that provider reimbursement will itself measure up to a specified standard, the section leaves the development of that standard to the states. The section expressly provides that payment rates are to be "determined in accordance with methods and standards developed by the states." The Ninth Circuit concluded that it was the province of the federal district court to determine whether the actions and nonactions of the state (in making provider reimbursement) violate the standard set out in 42 U.S.C. § 1396a(a)(13)(A). The words of the statute directly contradict this conclusion.

The recognition of personal statutory rights in the context of cooperative state-federal funding programs has significant effect on the balance of power between the governmental partners in the program. *Pennhurst I, supra.* As noted above, principles of federalism warrant requiring Congress to create those rights through "unmistakable language" *See Welch v. Texas Dept. of Highways and Public Transportation*, 55 U.S.L.W. at 5048 (quoting *Atascadero State Hospital v. Scanlon*, 473 U.S. 234, 243 (1985)). At a minimum, basic principles of legislative interpretation require that Congress create those rights through operative language. Congress has not done so here.

Furthermore, even when Congress has used "rights" language in a statute, that fact is not necessarily controlling. In *Pennhurst I, supra*, for example, the Court held that the "bill of rights" provision of the Developmentally Disabled Assistance and Bill of Rights Act of 1975, 42 U.S.C. §§ 6000 *et seq.* (1976 ed. and Supp. III), did not create substantive statutory rights, enforceable against the states. The legislative history and overall structure of the Act indicated only that Congress intended "to encourage, rather than mandate,

the provision of better services to the developmentally disabled." 451 U.S. at 20. The Court declined to give literal effect to provisions in the Act in which Congress made "findings respecting the rights of persons with developmental disabilities," 42 U.S.C. § 6010, primarily because, in the context of the cooperative state-federal funding program at issue in the case, treating Congress' findings as personal rights would impose "congressional policy on a state involuntarily." 451 U.S. at 16. The parts of the Medicaid Act relied upon by plaintiffs contain no language that effectively embodies the privileges allegedly created; indeed, the legislative history and overall structure of the Act refute plaintiffs' contentions.

D. The Legislative History of 42 U.S.C. § 1396a(a)(13)(A).

The provider reimbursement provisions contained in 42 U.S.C. § 1396a(a) and its implementing regulations are the culmination of a consistent legislative trend away from centralized, federal control of provider reimbursement standards and practices and toward greater delegation of reimbursement responsibility to participating states. The current reimbursement provisions, enacted in 1980,[21] are the product of congressional and administrative trial and error since the Medicaid Act became law in 1965.[22] As their history demonstrates, they are the product of a conscious and informed congressional decision to leave the development of provider reimbursement rates, the administration of reimbursement programs, and the review of individual reimbursement decisions to the state participants in the joint state-federal Medicaid venture.

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[21] The Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 962 (1980).

[22] Social Security Act Amendments of 1965, Pub. L. No. 89-97, Part 2, sec. 121 (1965).

As enacted in 1965, reimbursement standards were so general that states adopted either arbitrary flat rates or, more commonly, resorted to the rate methodology of the federal Medicare program. Costs spiraled, encouraging Congress to amend the Act in 1972. *See generally Mississippi Hosp. Ass'n, Inc. v. Heckler*, 701 F.2d 511 (5th Cir. 1983) and discussion therein; Preamble to Interim Final Rule for Medicaid Program; Payment for Long Term Care Facility Services, 46 Fed. Reg. 47,964 (1981). Under the 1972 language, states were to pay for intermediate care facility services "on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the state on the basis of cost finding methods approved and verified by the Secretary." 42 U.S.C. § 1396a(a)(13)(E) (1974). The change was intended to permit states to experiment with methods and standards for payment that would be simpler and less expensive than the complex Medicare reasonable-cost formula. *See* S. Rep. No. 1230, 92d Cong., 2d Sess. 287-88 (1972). Congress therefore declined to mandate any particular formula for reimbursement, choosing instead to delegate to the states the responsibility to design their own methodologies subject to close federal administrative oversight.[23]

The 1972 amendments failed to achieve their basic cost-containment objectives. Equally problematic, they proved to be a disincentive to state flexibility. Complex HEW regulations and a rigorous federal approval process for alternative

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[23] The requirement in the 1972 amendments that the Department of Health, Education and Welfare (HEW) "approve and verify" each state's cost finding method led the agency to adopt a series of complex regulations governing state reimbursement practices. For example, HEW promulgated detailed regulations prescribing definitive upper and lower limits on the acceptable range of "reasonable costs." 42 C.F.R. §§ 450.30(a)(3)(iv)(A), 450.30(b)(6) (1977). *See also* 41 Fed. Reg. 27,300 at 27,301-04 (1976) and 43 Fed. Reg. 4,861 at 4,862 (1978). Significantly, HEW accepted as part of its obligation under the statute the responsibility to review and approve the state's methods for rate-setting and cost-finding, and also "to assure that the methodologies *in fact* result in reasonable cost-related reimbursement." 41 Fed. Reg. at 27,300 (emphasis added).

state reimbursement methodologies mired the states in a bureaucratic bog of red tape and administrative paperwork. States generally were forced to abandon their attempts to devise alternative reimbursement systems and to adhere instead to Medicare reimbursement principles, which met with automatic approval. *See* Senate Finance Comm. S. Rep. No. 471, 96th Cong., 1st Sess. 28-29 (1979). Both of these results defeated the purpose of the 1972 amendments. Congress had intended neither to subject the states to administratively burdensome federal review, nor to have them follow as a matter of course the inherently inflationary Medicare principles which provided no incentive for efficient performance. *Ibid. See also* 46 Fed. Reg. at 47,965-66. Accordingly, in 1980, Congress amended the Medicaid Act in a more radical way.

The 1980 changes, which resulted in the statute's current reimbursement provisions, altered fundamentally the allocation of responsibility and authority for reimbursement rate-setting and review as between the states and the federal government. The amendments delegated to the states the responsibility to develop methods and standards for setting reimbursement rates. Moreover, the 1980 provisions entrusted the states, not the federal government, with the responsibility to determine that the reimbursement rates are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities. Again, as in 1972, the objective was to provide the states flexibility in developing methods of payment for their Medicaid programs in order to break away from the inflationary and cost-ineffective Medicare practices. *See* S. Rep. No. 471 at 28-29. This time, however, that objective was achieved by maximizing state discretion and responsibility for developing and admin-

istering state plans while minimizing federal administrative oversight and second-guessing.[24]

HCFA was well aware of Congress' objectives in amending the Medicaid Act in 1980 and promulgated its regulations accordingly. *See generally* 46 Fed. Reg. at 47,964-66. HCFA's regulations therefore echoed the language of the statute, directing the states to develop payment methods and standards and leaving it to the states to find that the rates are reasonable and adequate to meet the costs of efficient and economic providers. 42 C.F.R. § 447.252 (1981). Significantly, HCFA further mandated that each state agency develop a provider appeals process. 42 C.F.R. § 447.258 (1981). The federal agency defended the requirement as desirable because "individual facility rates will not receive Federal review under the revised regulations." 46 Fed. Reg. at 47,969. The federal agency was lobbied to provide national standards for Medicaid administration by defining terms such as "efficiently and economically operated facility" and by developing explicit criteria for federal review of states' methods and standards for establishing payment rates. But in responding to comments on its 1981 interim rules, HCFA declined to do so. It reasoned that federal restrictions on state discretion would be inconsistent with congressional intent.[25]

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[24] As stated in the Senate Finance Committee Report:

> The Congress expects that the Secretary will keep regulatory and other requirements to that minimum necessary to assure proper accountability, and not to overburden the States and facilities with marginal but massive paperwork requirements. It is expected that the assurances made by the States will be considered satisfactory in the absence of a formal finding to the contrary by the Secretary.

Id. at 29.

[25] For example, HCFA stated:

> We can appreciate the desire for explicit criteria for Federal review of States' methods and standards for establishing payment rates. However, we feel that such a list of criteria may be viewed as

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The history of the current provisions of the Medicaid Act serves to underscore the conclusion that Congress did not create an enforceable right for providers to be reimbursed at a federally prescribed level. After fifteen years of experimentation with federal reimbursement standards in an effort to control escalating costs, Congress settled upon a new allocation of responsibility for developing and administering provider reimbursement rates: Congress elected to make reimbursement standards a discretionary matter of state law.

E. Purpose of the Medicaid Act.

Congressional intent is the polestar in determining whether an Act of Congress creates personal rights. *Pennhurst I*, 451 U.S. at 15; *Cort v. Ash*, 422 U.S. at 78. A variety of factors aid in the determination of congressional intent. However, absent an express declaration of purpose either to confer or to withhold such rights, there are no magic incantations that, when included in a statute, mean that new personal rights necessarily flow from it.

> In expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law and to its object and policy.

Pennhurst I, 451 U.S. at 18 (*quoting Philbrook v. Glodgett*, 421 U.S. 707, 713 (1975)).

The assessment of the "object and policy" of a congressional act must be guided by basic constitutional

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> imposing Federal standards for payment rates, an effect that would be contrary to legislative intent.

Preamble to Final Rule, Medicaid Program; Payment for Long-Term Care Facilities and Inpatient Hospital Services, 48 Fed. Reg. 56,046 at 56,050 (1983).

facts: Congress possesses only limited powers; its authority is constrained by the distribution of power among the branches of government and between the federal and state governments; and Congress' enumerated powers have at least as much to do with the regulation of individual conduct, the allocation of government power, and the funding and preservation of government operations as with the definition of individual liberties. *See* L. TRIBE, AMERICAN CONSTITUTIONAL LAW § 5-1, at 224 (1978). Congress also must be charged with the knowledge that, because of 42 U.S.C. § 1983, the creation of federal statutory rights necessarily authorizes the enforcement of those rights against state officials in federal court. It is appropriate, therefore, when determining whether Congress intended to create a statutory right, to consider whether federal judicial oversight would tend to advance or to frustrate the overall purpose of the law.

Discovery of the specific constitutional authority relied upon by Congress in enacting legislation sheds considerable light on the "object and policy" of the Act in question. When, for example, Congress acts pursuant to section 5 of the Fourteenth Amendment to enforce constitutional rights, an intent to create enforceable statutory rights readily may be inferred. *See, e.g., Fitzpatrick v. Bitzer*, 427 U.S. 445 (1976); *Oregon v. Mitchell*, 400 U.S. 112 (1970); *Katzenbach v. Morgan*, 384 U.S. 641 (1966). On the other hand, when Congress authorizes expenditures to provide for the common defense, there is no basis to conclude that Congress intended to create personal rights, even though specific individuals may benefit from its action. Between these two extremes, the legislative power source may be less definitive, but it nevertheless is significant evidence of congressional purpose.

The purpose of Spending Clause legislation such as the Medicaid Act can be discerned fairly easily from the terms and conditions that Congress attaches to its expenditure of public

moneys. As a constitutional matter, the expenditure must be for the "general Welfare," U.S. Const. art I, § 8, cl. 1, a stipulation which suggests, at least as a starting point, an orientation toward producing benefits for the public at large rather than creating special personal entitlements. *Cf.*, *Cannon v. University of Chicago*, 441 U.S. at 690 n. 13.

More importantly, when, as in the Medicaid program, Congress uses its spending power to create state-federal cooperative funding programs, this Court has pointedly emphasized the importance that Congress clearly state the conditions it attaches to participation in the program so that states may make an informed choice whether to participate. *Pennhurst I*, 451 U.S. at 17. As noted above, the effect of finding a congressional intent to create personal statutory rights is to subject state officials to potential liability under 42 U.S.C. § 1983, each time it is alleged that their conduct violated the terms of the federal statute. In the context of state-federal cooperative programs, recognition of personal statutory rights can subject large categories of state action to federal judicial review. This fact obviously is significant to the states in deciding whether to participate in the Medicaid program. Therefore, a determination that Congress intended to create personal rights through the provisions of the Medicaid Act should only be made upon the most unambiguous expression of such intent. As the Court noted in *Pennhurst I*:

> Unlike legislation enacted under § 5, however, legislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the states agree to comply with federally imposed conditions. The legitimacy of Congress' power to legislate under the spending power thus rests on whether the state voluntarily and knowingly accepts the terms of the "contract." . . . There can, of course, be no knowing acceptance if a state is unaware of the conditions or is unable to ascertain what is

> expected of it. Accordingly, if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously. . . . By insisting that Congress speak with a clear voice, we enable the States to exercise their choice knowingly, cognizant of the consequences of their participation.

451 U.S. at 17 (citations and footnotes omitted).

If Congress intended to create a personal right for providers to be reimbursed for Medicaid services at a particular level, according to a federal standard, it failed miserably to express that intent with a clear voice. In electing to participate in the Medicaid program, no state reasonably could have known that it was agreeing to subject every individual provider reimbursement decision to federal judicial review through 42 U.S.C. § 1983.

In fact, the entire thrust of the Medicaid Act and its scheme for provider reimbursement manifests Congress' objective to leave the development of provider reimbursement rates, the administration of reimbursement programs, and *the review of individual reimbursement decisions*[26] to the states. The principle underlying the Medicaid funding scheme is that medical costs can be managed more effectively through decentralized state-administered control. The statutory scheme contemplates and facilitates diversity in reimbursement practices and levels from state to state. It would be a peculiar sort of federal statutory right whose shape and substance varied so greatly from state to state, depending upon each state's level of commitment to the cooperative Medicaid program.[27]

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[26] 42 C.F.R. § 447.253(c) (1984).

[27] Ironically, recognition of a federal statutory right to a provider reimbursement level as specified in state Medicaid plans would have the greatest impact in those states with the most comprehensive Medicaid programs and the most detailed and ambitious reimbursement rate structure. The more thorough a state is in developing its rate structure, the greater would be the state's potential exposure to liability under 42 U.S.C. § 1983. The creation of such counterproductive incentive systems should not be attributed promiscuously to Congress.

Moreover, the reimbursement provisions in the Medicaid Act reflect at least as much concern with ensuring that provider payments are not unreasonably or unnecessarily *high*, as with guaranteeing that providers are adequately compensated for their efforts. Federal concern with controlling Medicaid costs is more than a mere nod to the fiscal problems of the state. Medicaid is largely funded by *federal* money. It is logical, therefore, for Congress to condition payments to state Medicaid programs on assurances that the money will be carefully spent.

The Act is replete with such conditions. For example, the state plan must provide methods and procedures to "safeguard against unnecessary utilization of such care and services . . . and to assure that payments are consistent with efficiency economy, and quality of care." 42 U.S.C. § 1396a(a)(30)(A). The state plan must provide regular prepayment and postpayment claims review "to ensure the proper and efficient payment of claims and management of the program." 42 U.S.C. § 1396a(a)(37)(B).[28]

In short, the Act requires states electing to participate in the Medicaid program to develop efficient provider reimburse-

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[28] HCFA regulations include provisions imposing upper limits on provider payments. 42 C.F.R. § 447.271 (1984) provides:

> (a) Except as provided in paragraph (b) of this section, the agency may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services.
>
> (b) The agency may pay a public provider that provides services free or at a nominal charge at the same rate that would be used if the provider's charges were equal to or greater than its costs.

42 C.F.R. § 447.253(b)(2) (1984) provides:

> (2) *Upper limits.* The Medicaid agency's estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services or long-term care facility services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

ment rates and processes. The Act contemplates that states will contract with providers to accomplish the purposes of the Medicaid program and it requires the states to describe in their Medicaid plans the terms and conditions upon which they will do so. The Act contemplates that provider reimbursement will be governed by state law and by the terms of provider contracts. As noted above, Congress did not express, or even hint at, an intent to create federal provider reimbursement rights. Equally important, recognition of such rights would undermine the basic purpose of the Act.

F. The Structure of the Medicaid Act.

The foregoing arguments establish that the existence of a federal statutory right to provider reimbursement would be inconsistent with the language, the history and the purpose of the Medicaid Act. There are also deeper factors, relating to the nature of state-federal relations, that caution against recognition of federal statutory rights in the context of "cooperative federalism" programs.[29] However, the consequences of the Ninth Circuit's holding that plaintiffs have a federal claim under 42 U.S.C. § 1983 are not entirely theoretical.

The availability of federal judicial review of each state's provider reimbursement decisions, under different, state-established rates, potentially could leave the lower federal courts awash in complex, data-intensive provider appeals. The availability of § 1983 as an alternative remedy to the federally mandated state administrative procedures would encourage forum shopping, duplicative actions and inconsistent adjudications. These practical problems would arise largely from the fact that § 1983 actions challenging provider reimbursement decisions run counter to the basic structure of the Act.

In *Middlesex County Sewerage Authority v. National Sea Clammers Association, supra*, this Court held that 42 U.S.C.

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[29] *See* Part I, *supra* at p. 9-14, Part III, *infra* at p. 39-43.

§ 1983 could be foreclosed as a remedy for violation of statutory rights "[w]hen the remedial devices provided in a particular act are sufficiently comprehensive" as to demonstrate congressional intent to preclude § 1983 remedies. 453 U.S. at 20. In *Sea Clammers*, the Court assumed the existence of enforceable statutory rights and focused on the enforcement procedure included in the Federal Water Pollution Control Act itself as evidence of an implied withdrawal of other remedies. Although the Medicaid Act does not provide a comprehensive federal enforcement scheme for provider reimbursement, the Act comparably displaces a § 1983 remedy.

Consistent with its overall purpose of leaving the development and administration of provider reimbursement schemes to the states, the Medicaid Act directs that state Medicaid plans provide an administrative scheme for appeals by patients, 42 U.S.C. § 1396a(a)(3), and procedures for both prepayment and postpayment review of provider reimbursement claims, 42 U.S.C. § 1396a(a)(37)(B).[30] HCFA regulations require states to establish a procedure for provider appeals that allows individual provider challenges to state payment rates.[31] Congress' overt delegation of provider reimbursement review to the states is compelling evidence that

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[30] The fact that Congress directed states to provide for "fair hearings" to patients and for "claims review" of provider reimbursement claims is further evidence that Congress did not view health care providers as direct beneficiaries of the Act whose interests were deserving of special protection. *See Cannon v. University of Chicago*, 441 U.S. at 690, n. 13.

[31] 42 C.F.R. § 447.253(c) (1984). Although the federal regulation requires states to allow *administrative* review of provider appeals, Oregon law guarantees the availability of at least two levels of state court review, after the administrative proceeding. If plaintiffs had pursued their state remedies under the Medicaid program, their claim would have been reviewed by the state Medicaid agency. The agency decision would have been subject to review in the circuit (trial) court and then, by appeal, to the court of appeals. *See* Or. Admin. R. 461-09-000 (Fair Hearing Definitions); Or. Admin. R. 461-09-010 (The Hearing Request); Or. Admin. R. 461-09-011 (Group Fair Hearings); and Or. Admin. R. 411-70-435 (Provider Appeals). (Pet. App. I). *See also* Or. Rev. Stat. §§ 183.482 and 183.484 (Pet. App. J).

Congress considered the entire issue of reimbursement to be a matter of state concern, governed by state law, and administered exclusively by the states.

In this respect, *Sea Clammers* is directly analagous. Here, as in *Sea Clammers*, the nature of the remedial scheme prescribed in the substantive act indicates that Congress did not intend for 42 U.S.C. § 1983 to be available as a separate federal remedy.

It is entirely consistent with the nature of state-federal cooperative funding statutes for Congress to provide expressly that all or some aspects of the cooperative program will be administered *and reviewed* at the state, rather than the federal, level. Programs such as Medicaid essentially involve the allocation of government power and responsibility by agreement, between the participating governments. When, as in the case of provider reimbursement, the federal statute allocates to the states the power and responsibility to fix and administer rates, it follows logically that the responsibility to provide appropriate review of those rates also should be left to the states. If it can be said that the Medicaid statute creates "rights" to provider reimbursement, it is inherent in the nature of those rights that they are defined and enforceable under state law. *Cf. Daniels v. Williams*, ___ U.S. ___, 106 S.Ct. 662 (1986); *Davidson v. Cannon*, ___U.S. ___, 106 S.Ct. 668 (1986); *Parratt v. Taylor*, 451 U.S. 527 (1981) (state administrative and judicial review procedures may satisfy due process requirements).

Reimbursement review at the state level has the virtue of allowing individual reimbursement decisions to be reviewed in connection with state rates, by state tribunals familiar with the often complex state rate structures and reimbursement procedures. The unique "heavy cost" rule at issue in this case is a good example of the detailed provisions of state Medicaid plans that, under the Ninth Circuit's decision, federal district courts would be called upon routinely to construe.

Even if, as the Ninth Circuit apparently concluded, the federal statute in issue fairly could be read to prescribe a national standard applicable to the acts alleged in plaintiffs' complaint, the standard is so broad as to "simply defy judicial enforcement." *Wright v. City of Roanoke Redevelopment and Housing Authority*, ___ U.S. ___, 107 S.Ct. 766, 778 (1987) (O'Connor, J., dissenting). The Court should be reluctant to recognize an enforceable statutory right where Congress does not enunciate a standard by which the size and shape of that right readily may be measured and defined. "Congress sometimes legislates by innuendo, making declarations of policy and indicating a preference while requiring measures that, though falling short of legislating its goals, serve as a nudge in the preferred directions." *Rosado v. Wyman*, 397 U.S. 397, 413 (1970). When it does so, the Court should not readily interpret Congress' hortatory leanings as a mandate for judicial definition of "rights" toward which the Congress has left only the dimmest trail.

The recognition of a statutory right, and an attendant cause of action under 42 U.S.C. § 1983, can have dramatic consequences with respect to the allocation of responsibility for shaping national policy regarding the subject of the right. Congress here expressed no more than a goal of "reasonable and adequate" reimbursement, 42 U.S.C. § 1396a(a)(13)(A), and "reasonable access" to hospital services of "adequate quality." *Ibid.* Characterization of these broad objectives as rights effectively imputes to Congress an intent to require federal courts to flesh out critical aspects of national health policy. Just as the Court should be cautious in finding federal jurisdiction over claims that do not clearly fit within the terms of a jurisdictional statute, *Chapman v. Houston Welfare Rights Org.*, 441 U.S. at 612, so too should the Court be hesitant to assume responsibility for giving form and

substance to statutory rights. *See Wright v. City of Roanoke Redevelopment and Housing Authority*, 107 S.Ct. at 778 (O'Connor, J., dissenting). Caution particularly is appropriate in this case because plaintiffs' construction of the pertinent statute is fraught with serious constitutional problems under this Court's Eleventh Amendment jurisprudence.

III. The Ninth Circuit's Construction of 42 U.S.C. § 1396a Contradicts Well-Established Eleventh Amendment Precepts.

Caution governed neither the court of appeals' construction of the Medicaid Act, nor its consequent exercise of federal court jurisdiction over plaintiffs' claims. When the Ninth Circuit misconstrued 42 U.S.C. § 1396a as creating rights enforceable against the states in federal court, the court also violated a cardinal rule of statutory construction. If fairly possible, a statute should be construed to avoid serious constitutional problems. *International Machinists v. Street*, 367 U.S. 740, 749-50 (1961). Apparently blinded by its misreading of *Thiboutot*, the Ninth Circuit failed to see the obvious constitutional roadblock to its interpretation of the Medicaid Act: the Eleventh Amendment bars adjudication of plaintiffs' claims in federal court.

Plaintiffs sought, in federal court, retroactive monetary damages and prospective injunctive and declaratory relief against the state, one of its agencies and one of its officials. (J.A. at 7-9). Yet, despite the lack of any claim that the state had consented to be sued in federal court, the Ninth Circuit ignored the principles recently enunciated by this Court in *Pennhurst II* "that in the absence of consent a suit in which the State or one of its agencies or departments is named as the defendant is proscribed by the Eleventh Amendment" and "[t]his jurisdictional bar applies regardless of the nature of the relief sought." 465 U.S. at 100.

The appeals court also bypassed this Court's ruling in *Dept. of Health v. Florida Nursing Home Assn.*, 450 U.S. 147, 149-50 (1981). There, the Court directly held that the mere fact that a state participates in the Medicaid program does not constitute a waiver of Eleventh Amendment immunity. Consequently, Oregon's participation in the Medicaid program itself provides no basis for asserting federal court jurisdiction over the state.

Moreover, 42 U.S.C. § 1396a(a), contains no expression of congressional intent to abrogate the state's Eleventh Amendment immunity from suit in federal court. In fact, Congress expressly repealed an Eleventh Amendment waiver provision, which for a very brief time, was contained in the Medicaid Act.[32] When faced with another statutory scheme (§ 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 749) which similarly contains no expression of congressional intent to abrogate the states' sovereign immunity, this Court stated:

> [I]t is incumbent upon the federal courts to be certain of Congress' intent before finding that federal law overrules the guarantees of the Eleventh Amendment. The requirement that Congress unequivocally express this intention in the statutory language ensures such certainty.

Atascadero State Hospital v. Scanlon, 473 U.S. at 243. *See also Welch v. Dept. of Texas Highway and Public Transportation*, ___ U.S. ___, 107 S.Ct. ___, 55 U.S.L.W. 5046 (June 25, 1987).

The Ninth Circuit did not even acknowledge these principles, let alone follow this Court's holdings in *Atascadero*, *Welch* and *Florida Nursing Home Assn.* that, in comparable

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[32] Congress, on the last day of the 1975 session, amended the Medicaid Act to require participating states to waive their Eleventh Amendment immunity and consent to be sued in federal court by or on behalf of hospitals with respect to the payment of reasonable costs for hospital services. The Eleventh Amendment waiver/penalty provision raised a firestorm of protest by the states. *See* House Interstate and Foreign Commerce Committee, H. Rep. No. 1122, 94th Cong., 2nd Sess. 4, 5 (1976). Congress promptly repealed the provision the following year. Pub. L. No. 94-552 (1976).

circumstances, the state is immune from federal court suit. The Ninth Circuit evidently refused to be guided by this Court's Eleventh Amendment jurisprudence.

If, in reinstating plaintiffs' complaint, the Ninth Circuit meant only to restore plaintiffs' claims against the defendant state officer, it did not say so in its opinion. Instead, the appeals court opinion silently tolerated a § 1983 claim made against a state and one of its agencies in federal court. This precedent flies directly in the face of the holding in *Edelman v. Jordan*, 415 U.S. 651, 674-77 (1974) (*Edelman*), that § 1983 was not intended to create a waiver of a state's Eleventh Amendment immunity.[33]

With regard to plaintiffs' claims against the defendant state officer, the Ninth Circuit drew no distinction between claims for monetary relief and claims for injunctive relief. Clearly, however, the claim for retroactive monetary damages is barred by the Eleventh Amendment. Although this rule also was firmly established in *Edelman*, 415 U.S. at 666-71, and confirmed in *Pennhurst II*, 465 U.S. at 102-03, the Ninth Circuit paid the rule no heed. Nor did the lower court consider whether the claim for prospective relief is in reality a claim against the state which is barred by the Eleventh Amendment. This is just such a case.

In *Pennhurst II*, 465 U.S. at 101-02, this Court restated a fundamental Eleventh Amendment principle in the following terms:

> [A]s when the state itself is named as the defendant, a suit against state officials that is in fact a suit against the State is barred regardless of whether it seeks

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[33] Through lack of proper analysis, the Ninth Circuit appears to have assumed that the state is a "person" for purposes of 42 U.S.C. § 1983, and thus a proper party defendant in this action, notwithstanding "the threshold fact of congressional authorization to sue a class of defendants which *literally* includes states is wholly absent [from 42 U.S.C. § 1983]." *Edelman v. Jordan*, 415 U.S. 651, 672 (1974) (emphasis in original).

damages or injunctive relief. *See Cory v. White*, 457 U.S. 85, 91 (1982).

The Court in *Pennhurst II* recognized that under the fiction of *Ex parte Young*, 209 U.S. 123 (1908), the Eleventh Amendment does not bar a federal court suit against a state official for prospective injunctive relief from an alleged violation of *federal* law, because a state officer violating *federal* law is thereby stripped of authorization to act for the state. However, the Court observed that "the theory of *Young* has not been provided an expansive interpretation." *Pennhurst II*, 465 U.S. at 102 (citing *Edelman*). In *Pennhurst II*, this Court rejected the contention that federal courts have jurisdiction to entertain a suit for prospective relief against a state official alleged to have violated *state* law:

> In such a case the entire basis for the doctrine of *Young* and *Edelman* disappears. A federal court's grant of relief against state officials on the basis of state law, whether prospective or retroactive, does not vindicate the supreme authority of federal law. On the contrary, *it is difficult to think of a greater intrusion on state sovereignty than when a federal court instructs state officials on how to conform their conduct to state law. Such a result conflicts directly with the principles of federalism that underlie the Eleventh Amendment.* We conclude that *Young* and *Edelman* are inapplicable in a suit against state officials on the basis of state law.

465 U.S. at 106 (emphasis added). That rationale applies in this case.

Here, plaintiffs seek federal judicial enforcement of provisions of the state's Heavy Cost Program. That program is mandated and circumscribed exclusively by state law. No federal statute or regulation requires implementation of a "heavy cost" reimbursement program. Consequently federal court enforcement of the program will not "vindicate" the supremacy of federal law. Stated in *Ex Parte Young* terms,

failure by the state administrator to follow the requirements of state law would not deprive him of his authority to act for the state. The Eleventh Amendment, therefore, bars this action in federal court.

Plaintiffs presumably will assert that, in this case, state law has a federal overlay by virtue of the provisions of the federal Medicaid Act. But particularly in this area of state-federal cooperative funding programs, important values of federalism are at stake. Even if plaintiffs' claim meaningfully could be distinguished from the state law claim in *Pennhurst II*, due respect for the "constitutionally mandated balance of power between the States and the Federal Government," *Garcia*, 469 U.S. at 572 (Powell, J., dissenting), nevertheless requires more from Congress before state Medicaid officials may be hailed into federal court to answer claims challenging the state's cost reimbursement rates.

At a minimum, a state is entitled to prior notification by Congress of its susceptibility to federal court suit through an unequivocally expressed requirement of Eleventh Amendment waiver or an unequivocally expressed statement that Congress intends to abrogate the states' sovereign immunity in the federal Medicaid Act. As discussed above, however, no abrogation language is used in the Medicaid Act, a prior Eleventh Amendment waiver provision was repealed, and this Court already has determined that mere participation by a state in the Medicaid funding program does not constitute a waiver of Eleventh Amendment immunity.

Due consideration of these factors should have counselled the Ninth Circuit to re-examine its construction of the Medicaid Act; due regard for the constitutional significance of these factors compels a different construction of the statute.

CONCLUSION

Plaintiffs' complaint failed to state a cause of action or a basis for federal court jurisdiction. The Ninth Circuit misconstrued Title XIX of the Social Security Act when it

concluded that the plaintiffs were entitled to maintain an action in federal court under 42 U.S.C. § 1983. The Ninth Circuit, therefore, erred in reversing the district court's dismissal of the complaint. This Court should reverse the decision of the Ninth Circuit and remand with instructions to reinstate the judgment for defendants that was entered in district court.

Respectfully submitted,
DAVE FROHNMAYER
Attorney General of Oregon
WILLIAM F. GARY
Deputy Attorney General
JAMES E. MOUNTAIN, JR.
Special Counsel to the
Attorney General
VIRGINIA L. LINDER
Solicitor General
PHILIP SCHRADLE
Assistant Attorney General
Counsel for Petitioners